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Nebraska Health and Human Services System
Department of Regulation & Licensure
Division of Investigations
P.O. Box 95164
Lincoln, NE 68509
402-471-0175
Fax 402-471-6238

COMPLAINT FORM

INSTRUCTIONS: (Please type or print legibly.)

Please furnish all identifying information for the complainant, the patient and all practitioners and facilities involved in the complaint. Additional pages may be added if necessary.

PERSON MAKING COMPLAINT

NAME: _____
First Middle Last Maiden or other Names Used

ADDRESS: _____
Street City State Zip Code

HOME PHONE: _____ WORK PHONE: _____

May we contact you at your place of employment? YES ☐ NO ☐

PATIENT- CLIENT INFORMATION

NAME: _____
First Middle Last Maiden or Other Names Used

ADDRESS: _____
Street City State Zip Code

DATE OF BIRTH: _____

HOME PHONE: _____ WORK PHONE: _____

This Complaint is Being Filed Against

(1) NAME _____
First Middle Last

Office Address _____
Street Address

_____
City State Zip Code

(2) NAME _____
First Middle Last

Office Address _____
Street Address

_____
City State Zip Code

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Please sign form on next page

Please check your response to the below statements and then sign the form.
Don't forget to also fill out and sign the Release of Information Authorization form.

I agree to testify in any licensure hearings that may arise as a result of my complaint. ☐ YES ☐ NO

I grant my permission for the Division of Investigations to provide a copy of my narrative to the subject of my complaint. ☐ YES ☐ NO

The statements I have made are true and correct to the best of my knowledge and belief. ☐ YES ☐ NO

Date_____ Signed_____

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NARRATIVE
(Please type or print legibly)

Please describe in detail all allegations against the practitioner(s). Describe each incident with specific dates and list any witnesses. Attach copies of any documents you have concerning the allegations. Use additional sheets if necessary.

*Date of incident:*_____ *Patient/Client's Name:*_____

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RELEASE OF INFORMATION AUTHORIZATION

I authorize any person, including, but not limited to, hospitals, institutions, health care providers, mental health providers, clinics, employers (past and present), laboratories, attorneys, insurance companies, government agencies, or other public or private agencies to release to the Nebraska Health and Human Services Regulation and Licensure and the Nebraska Attorney General's Office, their representatives, agents or employees, any and all information about me, including documents, reports, records, files, testimony or any other documents regardless of form or content.

HIPAA: Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required. 45CFR 164.512 (d) Standard: Uses and disclosures for Health Oversight Activities. (1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions.

A copy of this authorization shall be as valid as the original.

Name: _____ _____
Print or Type Date of Birth

Signature: _____ _____
Date

Or:
_____ _____
Parent or legal guardian (if applicable) Relationship

DO NOT WRITE BELOW THIS LINE

.....

TO: _____

ADDRESS: _____

_____

Please submit copies of all records indicated below regarding the above release of information authorization. Thank you.

___FACESHEET	___HISTORY AND PHYSICAL	___PATHOLOGY REPORTS
___CONSULTATION	___PROGRESS NOTES	___EKG TRACINGS
___NURSES NOTES	___DISCHARGE SUMMARY	___LABORATORY REPORTS
___IMAGING REPORTS	___OPERATIVE REPORTS	___PHYSICIAN ORDERS
___EMERGENCY DEPT. RECORD		

OTHER:

_____
_____
_____
_____
_____

Please send information to:
Department of Health & Human Services Regulation & Licensure
Division of Investigations
Attn:
301 Centennial Mall South, P.O. Box 95164
Lincoln, NE 68509